Evidence for addition in #18 shown on:

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles Street, Baltimore

06869

# CERTIFICATE OF DEATH

FILM No. G 127 AUG 3 1950

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A. A. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 46 Fleet St Annapolis — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | STREET ADDRESS (If rural, give location) 46 Fleet |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Mary | Jane | Attwood | July | 19 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Divorced | Jan. 17, 1876 | 74 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Annapolis Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Moses Attwood | Kate Hammond |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Arteriosclerotic heart disease | 20 y |
| 199.1 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) abdominal tumor - probably benign. (8-3-50 - ams) | 5 mo |
| 55e (c) intestinal obstruction | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. gen arteriosclerosis | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from July 3, 19 50, to July 19, 19 50, that I last saw the deceased alive on July 17, 19 50, and that death occurred at 2 30 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Edith Poolier | M. D. | 42 State Circle Annapolis, Md. | 7-21-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | July 23 1950 | Brewer Hill | Annapolis | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| July 23, 1950 | Mary J. Grundy | J. B. Johnson | Annapolis Md |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

I

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

06870

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nova Annapolis
LENGTH OF STAY (In this place) 1 month 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Narragansett Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE California COUNTY Santiago
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Imperial Beach
STREET ADDRESS (If rural give location) Ocean Blvd.

3. NAME OF DECEASED (Type or Print) (First) OLTON (Middle) RADER (Last) BENNEHOFF
4. DATE OF DEATH (Month) July (Day) 17 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feby 14, 1896
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rear Admiral
10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John Bennehoff
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Retired Navy 1 & II
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. O. R. Bennehoff

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Acute Coronary Occlusion | sudden |
| 94a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Sclerosis | 2 years |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 7-17-50

23. BURIAL, ~~CREMATION REMOVAL~~ (Specify) DATE THEREOF July 25-1950 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. July 24, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor-Son ADDRESS Annapolis Md.

11296

RECEIVED
JUL 25 1950
BUREAU V. S.

06871

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md. — LENGTH OF STAY (in this place) 48 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Annapolis, Md COUNTY A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 99 Calvert St.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) W. P. (Last) Booth
4. DATE OF DEATH (Month) 7 (Day) 6 (Year) 1950
5. SEX M.
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 1-1-1902
9. AGE last birthday 48 yrs. — If under 1 year: Months 7, Days 6 — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Naval Amd
10b. KIND OF BUSINESS OR INDUSTRY Building Alt.
11. BIRTHPLACE (State or foreign country) Balto., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Charles Booth
14. MOTHER'S MAIDEN NAME Mary Booth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Estella Stevens

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary disease — one hour.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION NONE.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) MD. ADDRESS Easport, Md DATE SIGNED 7/6/50.

23. BURIAL, CREMATION REMOVAL (Specify) — DATE THEREOF 8 July 1950 — NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery — LOCATION (City, town, or county) Annapolis AA (State) Md.

DATE REC'D BY LOCAL REG. July 7, 1950 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR William Reese — ADDRESS 108 Wash. St. Annapolis, Md. XVXV9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06872

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 9 mos. 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Paris, Calvert County, Maryland
STREET ADDRESS (If rural give location) not known

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) (Last) Bradley

4. DATE OF DEATH (Month) 7/24/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: not known 1890

9. AGE last birthday: 60 yrs. If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE: Calvert, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hillery Bradley

14. MOTHER'S MAIDEN NAME: Annie Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ********** 16. SOCIAL SECURITY NO. **********

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Myocarditis | known since 10/8/49 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Senile Psychosis | known since 10/8/49 |

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/8/49, 19..., to 7/24/50, 19..., that I last saw the deceased alive on 7/24/50, 19..., and that death occurred at 1:00 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Janet Marguerite M.D. Crownsville, Maryland 7/24/50

23. BURIAL, CREMATION REMOVAL, (Specify) Burial | DATE THEREOF 7-26-50 | NAME OF CEMETERY OR CREMATORY St Edmonds | LOCATION (City, town, or county) Calvert Co (State) Md

DATE REC'D BY LOCAL REG. July 24, 1950 | REGISTRAR'S SIGNATURE Mrs. E. F. Joyce

24. FUNERAL DIRECTOR C. E. Sewell Conner Frederick Md ADDRESS

98899

RECEIVED
JUL 26 1950
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

06873

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS DOA Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis - Weems Creek
STREET ADDRESS (If rural, give location) RFD Annapolis, Maryland

3. NAME OF DECEASED (Type or Print) (First) BENJAMIN (Middle) C (Last) BRITTON, JR

4. DATE OF DEATH (Month) July (Day) 23, (Year) 1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH March 5, 1915
9. AGE last birthday 35 yrs. If under 1 year Months 4 Days 18 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor
10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery and Meat Store
11. BIRTHPLACE (State or foreign country) West Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin C. Britton, Sr.
14. MOTHER'S MAIDEN NAME Rose Eva Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Theresa Britton Weems Creek RFD Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary Occlusion | Sudden |
| 940 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | unknown |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 26, 1950
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) Annapolis, Maryland (State)

DATE REC'D BY LOCAL REG. July 24, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

15661

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 25 1950
BUREAU V. S.

06874

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum (Rural) LENGTH OF STAY (in this place) 1 Years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum (Rural) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 1315 Broad View Blvd. | STREET ADDRESS (If rural, give location) 1315 Broad View Blvd. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Annette | (Middle) | (Last) Brown | 4. DATE OF DEATH | (Month) July (Day) 29 (Year) 1950 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Oct. 16, 1887 | 9. AGE last birthday 62 yrs. | If under 1 year Months / Days; If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Arbutus, Balto., Co., Md. | 12. CITIZEN OF WHAT COUNTRY? us | | |
| 13. FATHER'S NAME John Thomas Tayman | 14. MOTHER'S MAIDEN NAME Amanda Chaney | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS Bertram G. Brown, 1315 Broad View Bl Linthicum, Md. | | | |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Uremia | 1 mo. |
| 331x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardiovascular Disease c̄ Chronic nephritis | 13 yrs. |
| 131a | (c) Cerebral hemorrhage c̄ residual left hemiplegia | 13 yrs. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from April 3, 1950, to July 29, 1950, that I last saw the deceased alive on July 29, 1950, and that death occurred at 12 NOON m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| C. Milton Linthicum | M.D. | Linthicum Hgts, Md. | July 31, 1950 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Aug. 1, 1950 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) (State) Glen Burnie, Md. |
| DATE REC'D BY LOCAL REG. 8/1/50 | REGISTRAR'S SIGNATURE L. J. DeAlba | 24. FUNERAL DIRECTOR R V Sigleton | ADDRESS Glen Burnie, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
AUG 12 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06875

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis; LENGTH OF STAY (In this place) 43 Yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

STREET ADDRESS (If rural give location) 71 College Creek Terrace

3. NAME OF DECEASED (Type or Print): (First) Lloyd; (Middle) E.; (Last) Browne

4. DATE OF DEATH: (Month) (Day) (Year) 7/29/50 19

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 7/29/1894

9. AGE last birthday: 56 yrs. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): A. A. Co. Maryland

12. CITIZEN OF WHAT COUNTRY? ----

13. FATHER'S NAME: Lloyd E. Browne

14. MOTHER'S MAIDEN NAME: Harriett Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ----------

17. INFORMANT: J. Burnette Browne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause (a) Coronary Sclerosis Heart Disease — Interval Between Onset and Death: 3 years

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension, cerebral Hemorrhage — 1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1944, to July 29, 1950, that I last saw the deceased alive on July 29, 1950, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo. C Boarman M.D. Annapolis Md. 8-2-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 8/2/50

NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery

LOCATION (City, town, or county) (State) West St. Annapolis, Md.

DATE REC'D BY LOCAL REG. Aug. 2, 1950

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Mrs. Charles E. Hicks&Son-45 Northwest St.

72071

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 3 1950
BUREAU V. S

06876

# MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (In this place) 7 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridge Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
STREET ADDRESS (If rural give location) Ridge Road

3. NAME OF DECEASED (Type or Print): (First) GRANSON (Middle) WILLIAM (Last) BURLEY

4. DATE OF DEATH: (Month) July (Day) 10 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: about 1880

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Gabe Burley

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Annie Leech

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Dilatation of Heart | Sudden |
| 443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Chronic Myocarditis | Unknown |
| | (c) Hypertensive Cardio-Vascular Disease | Unknown |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): John M. Leffy M.D. Deputy Med. Examiner — ADDRESS: Annapolis Md — DATE SIGNED: 7-10-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 7-15-50 — NAME OF CEMETERY OR CREMATORY: Gamble Md — LOCATION (City, town, or county): A.A. Co. Md (State)

DATE REC'D BY LOCAL REG.: July 14-50 — REGISTRAR'S SIGNATURE: A. W. Hedrick — 24. FUNERAL DIRECTOR: W. B. Spriggs — ADDRESS: 139 W. Hemlock St.

866W

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

06877

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Winterson's Beach, St. Margarets

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) Pleasant

3. NAME OF DECEASED (Type or Print): (First) MYRTLE (Middle) H. (Last) CHAMBERS

4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 22, 1923

9. AGE last birthday: 27 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S. A

13. FATHER'S NAME: James Howard

14. MOTHER'S MAIDEN NAME: Agnes Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.:

17. INFORMANT: Agnes Porter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Drowning

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

INTERVAL BETWEEN ONSET AND DEATH

929.8
183

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, firm, factory, street, office building, etc.) OF INJURY Mill Creek (CITY OR TOWN) near Annapolis (COUNTY) A. A. (STATE) Md

TIME OF INJURY (Month) June (Day) 2 (Year) 1950 (Hour) 3½ p.m. INJURY OCCURRED While at work ☐ Not while at work ☑ HOW DID INJURY OCCUR? Was bathing in Creek about 20 feet from shore

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-4-50

23. BURIAL, CREMATION, REMOVAL (Specify): Buried DATE THEREOF July 5/50 NAME OF CEMETERY OR CREMATORY Broadneck LOCATION (City, town, or county) St. Margarets (State) Md

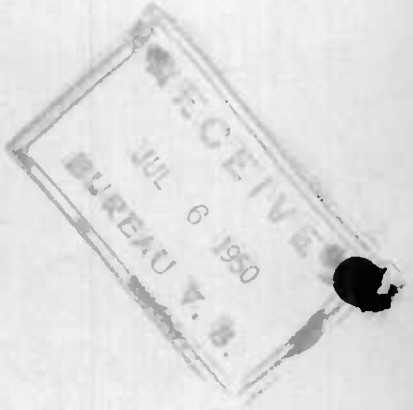
DATE REC'D BY LOCAL REG. Broadneck July 5, 1950 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR J. B. Johnson ADDRESS

VS. A15A

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JUL 6 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06878

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
MARYLAND
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mayo, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Mayo
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo Post Office
STREET ADDRESS (If rural, give location): Mayo, Maryland

3. NAME OF DECEASED (Type or Print): (First) DAVID (Middle) WEST (Last) COLLISON

4. DATE OF DEATH: (Month) July (Day) 31, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan. 21, 1871

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Mayo, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nich Collison

14. MOTHER'S MAIDEN NAME: Susian Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Minnie E. Collison Mayo, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Insufficiency, Acute — Instant

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis — 15 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 30, 1949, to July 31, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE: Vincent Gould (Degree or title) M.D. ADDRESS: Mayo, Maryland DATE SIGNED: 8-1-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: August 3, 1950
NAME OF CEMETERY OR CREMATORY: Mayo Memorial Cemetery
LOCATION (City, town, or county) (State): Mayo, Maryland

DATE REC'D BY LOCAL REG.: Aug. 2, 1950
REGISTRAR'S SIGNATURE: Edward Collinson

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 9 1960
BUREAU V. S

Evidence for change of sex shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06879

FILM No. G 127 AUG 1 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CROWNSVILLE (RURAL) LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mrs. WILSON'S NURSING HOME.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAD COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ODENTON.
STREET ADDRESS (If rural, give location) SECOND AVE (PATUXENT)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) E. (Last) CRAWFORD.
4. DATE OF DEATH (Month) JULY (Day) 24 (Year) 1950
5. SEX FEMALE MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW.
8. DATE OF BIRTH Nov. 26, 1869
9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) SPRINGFIELD PRINCE GEORGE Co.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME BENJAMIN F. MIDDLETON
14. MOTHER'S MAIDEN NAME SARAH WARD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AND ADDRESS FIELDER CRAWFORD, ODENTON, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Hypertensive Cardio-Vascular disease | 2 Years |
| 443x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| 93d | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to July 24, 1950, that I last saw the deceased alive on July 23, 1950 and that death occurred at 12:45 P.m., from the causes and on the date stated above.

SIGNATURE Edward G Thewett (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED July 25 1950

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL DATE THEREOF JULY 28, 1950 NAME OF CEMETERY OR CREMATORY TRINITY CHURCH YARD LOCATION (City, town, or county) ODENTON (RURAL) (State) MD

DATE REC'D BY LOCAL REG. 7/25/50 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR Thomas W. Burgleton ADDRESS Glen Burnie, Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
JUL 27 1990
BUREAU V. A.

ROBERT HENRY CROMER

06880

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
LENGTH OF STAY (in this place) Since 6/7/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest N. Home.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1325 East North Ave.

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) Henry (Last) Cromer

4. DATE OF DEATH (Month) July (Day) 14 (Year) 1950

5. SEX M.
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH March 3-1875
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Polisher Retired 10 yrs
10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Co
11. BIRTHPLACE (State or foreign country) Harrisonburg - Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Daniel Cromer
14. MOTHER'S MAIDEN NAME Mary Gilmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Cedar Crest N. Home, Severna Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| 592x | Immediate cause | (a) Mitral Insufficiency | Over 1½ mo |
| 131a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Interstitial Nephritis | Unknown |
| | | (c) Senility | Unknown |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Prostatitis — Unknown

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 1950, to June 13, 1950, that I last saw the deceased alive on 6/13/50, 19....., and that death occurred at 5:20 A. m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faubert M.D. (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 7/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 17-1950
NAME OF CEMETERY OR CREMATORY Govans Presbyterian
LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. July 15-1950
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

496 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06881

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie; MARYLAND; LENGTH OF STAY (in this place) 2 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 429 Maple Lane N.W

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie; STREET ADDRESS (If rural give location) 429 Maple Lane

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Dewey (Last) Crosby

4. DATE OF DEATH: (Month) 7 (Day) 25 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH 3-22-1898

9. AGE last birthday 52 yrs. If under 1 year: Months —; Days —. If under 24 hrs.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitting

10b. KIND OF BUSINESS OR INDUSTRY? Ship yard

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Francis

14. MOTHER'S MAIDEN NAME Adeline Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-10-5072

17. INFORMANT Doris Barker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Carcinomatosis | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma Colon | 7 mos |
| | (c) | |

153X
46e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION December 49

19b. MAJOR FINDINGS OF OPERATION Carcinoma Colon

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-18, 1950, to 7-24, 1950, that I last saw the deceased alive on 7-24, 1950 and that death occurred at 7 30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Charles R. MacDonald M.D. ADDRESS Glen Burnie, Md DATE SIGNED 7-25-50

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | DATE THEREOF July 26, 1950 | NAME OF CEMETERY OR CREMATORY TRINITY METHODIST CHURCH | LOCATION (City, town, or county) ODENTON (Anne Arundel) | (State) MD

DATE REC'D BY LOCAL REG. July 25 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR Thomas W. Dingleton ADDRESS

988 4V

RECEIVED
JUL 27 1950
BUREAU Y. S.

06882

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2 7

**1. PLACE OF DEATH:**

County: A. A.

City or town: Dorsey Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: A. A. C.

City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Florence Dailey.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | C. | Widow |

6.(b) Name of husband or wife: Rufus Dailey.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1892.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 1 | | ..... hrs. ..... min. |

9. Birthplace: Woodwine Howard Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown.
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rachel Dorsey.
15. Birthplace: Md.

16. Informant: William Hall.
Address: 1944 Ridgehill Ave. Balto. City

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 7/31/50 (month) (day) (year)

Cemetery or crematory: St. Marks

Location: Ridge Rd. Hanover R.F.D.

18. Funeral director: Kate Williams
Address: 3211 N. Schroeder St. Baltimore, Md.

19. July 30 1950 Clara Hasleh
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: July 29 1950 at 12 15/2 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1949, to July 29 1950 and that I last saw her alive on July 1950

Immediate cause of death: Hypertensive Cardio-Vascular Disease — DURATION: 1 yr.

Due to: Hypertension & arterio-Sclerosis — 3 yrs.

Due to:

Other conditions: 443X
93d
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Mark Shipley, M.D.
M. D. or other

Address: Savage, Md. Date signed: 7/31/50

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

RECEIVED
AUG 8 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

06883

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1004 Sarah Anne Street

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) (Last) Dixon

4. DATE OF DEATH: (Month) 7/10/50 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1899

9. AGE last birthday: 51 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: Ella Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ********

16. SOCIAL SECURITY NO.: not known

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): General Paresis — Interval between onset and death: known

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b): — since 11/2/45

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 11/2/45, 19..., to 7/10/50, 19..., that I last saw the deceased alive on 7/10/50, 19..., and that death occurred at 4 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Marguiten M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 7/10/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 7/24/50 — NAME OF CEMETERY OR CREMATORY: Hospital Cemetery — LOCATION (City, town, or county) (State): Crownsville, Maryland

DATE REC'D BY LOCAL REG.: July 24, 1950 — REGISTRAR'S SIGNATURE: E. Gretchen Joyce

24. FUNERAL DIRECTOR — ADDRESS: Supt. Hospital — Crownsville Md.

RECEIVED
DEC 25 1950

The date of burial on Gertrude Dixons death certificate was July 24, 1950. The permit states she was buried on the 25th. The man from Crownsville did not get his permit until fairly late in the afternoon so perhaps he didn't return early enough for a burial. Will leave my copy July 24 until I get a correction slip from your office to change.

06884

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

Dr. Klawans

| | |
|---|---|
| 1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: St. Margarets |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General | STREET ADDRESS (If rural, give location): nr Annapolis, Md. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): JOSEPHINE C. EHLE [redacted] | | | 4. DATE OF DEATH (Month) (Day) (Year): &*"* 7-2-50 19 | | |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: Dec. 22, 1870 | 9. AGE last birthday: 79 yrs. | If under 1 year: Months 7 Days 10 — If under 24 hrs.: Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife | 10b. KIND OF BUSINESS OR INDUSTRY: own | 11. BIRTHPLACE (State or foreign country): Sweeden | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: John Samson | | 14. MOTHER'S MAIDEN NAME: Ubjbiwh | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): no | 16. SOCIAL SECURITY NO.: NONE | 17. INFORMANT AND ADDRESS: Mr. Paul S. Ehle St. Margarets, Md. | | | |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Intestinal Obstruction | 3 days |
| 570.2 Antecedent cause(s) | (b) Probably Mesenteric Thrombosis | 3 days |
| 117b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Duodenal ulcer | No. standing |

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 6/29, 1950, to 7/2, 1950, that I last saw the deceased alive on 7/1, 1950, and that death occurred at 3 30 A m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Maurice Klawans, Md | Annapolis Md | 7/3/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 7-5-50 | Cedar Bluff Cemetery | Annapolis, Maryland |

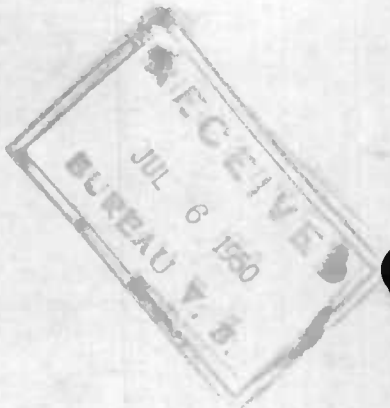
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| July 3, 1950 | [signature] | B.L. Hopping and Son | Annapolis, Md. |

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415


RECEIVED
JUL 6 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06885

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester — LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) HARRY (Middle) T (Last) FRANTUM

4. DATE OF DEATH: (Month) July (Day) 18, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 30, 1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months 11, Days — If under 24 hrs.: Hours, Min. 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: groundskeeper

11. BIRTHPLACE (State or foreign country): Anne Arundel Co, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unk.

14. MOTHER'S MAIDEN NAME: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs Edith Frantum Wife Winchester, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis — Sudden

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis — 3 years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — Several years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1947, to July 18, 1950, that I last saw the deceased alive on July 13, 1950, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Boxil - M.D. Annapolis Md 7-18-50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 7-21-50 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. July 19 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS B.L. Hopping and Son Annapolis, Md.

RECEIVED
JUL 20 1950
BUREAU V. S.

06886

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Meade Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same ODENTON
STREET ADDRESS (If rural, give location) FT. MEADE ROAD, ROUTE 175 BOX 204

3. NAME OF DECEASED (Type or Print) (First) Lena (Middle) Anna (Last) Gardner.
4. DATE OF DEATH (Month) July (Day) 7 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married
8. DATE OF BIRTH 6/6/87
9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bowie, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Rinaldo Bryant.
14. MOTHER'S MAIDEN NAME Estelle Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. No
17. INFORMANT Mr. Wm. Gardner (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Occlusion — Sudden

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Pauber Md. (Degree or title) assistant Deputy Medical Examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 7/8/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF JULY-10-1950
NAME OF CEMETERY OR CREMATORY GLEN HAVEN
LOCATION (City, town, or county) GLEN BURNIE (State) MD
DATE REC'D BY LOCAL REG. 7/8/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR [signature] ADDRESS Glen Burnie Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 11 1950
BUREAU V. S.

06887

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 218 McKendree Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 218 McKendree Ave.

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) J. (Last) George

4. DATE OF DEATH (Month) 7 (Day) 11 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~MARRIED,~~ ~~(Specify)~~
8. DATE OF BIRTH 7/30/1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Williamsport Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Scott Robinson
14. MOTHER'S MAIDEN NAME Sarah K. Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Leon George Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 days

331X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

83a

(c) — Several Yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 8, 1950, to July 11, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 7-12-50

23. ~~BURIAL, CREMATION REMOVAL (Specify)~~ Removal
DATE THEREOF 7/13/50
NAME OF CEMETERY OR CREMATORY River View
LOCATION (City, town, or county) (State) Williamsport Md.

DATE REC'D BY LOCAL REG. July 13, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 14 1950
BUREAU W. M.

Dr Basil

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

66888

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 934 Bay Ridge Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 934 Bay Ridge Ave.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) BETTY MAY BARBARA GODDARD

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1950 19

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH July 7, 1934

9. AGE last birthday 16 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10b. KIND OF BUSINESS OR INDUSTRY High School

11. BIRTHPLACE (State or foreign country) Eastport, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James L. Goddard

14. MOTHER'S MAIDEN NAME Hilda Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mr James L. Goddard 934 Bay Ridge Ave. Eastport, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Epilepsy

353.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

85 (c)

INTERVAL BETWEEN ONSET AND DEATH: Several years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Convulsions

Several years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1948, to July 26, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 6.30 a.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M-D ADDRESS Humphrey Md DATE SIGNED 7-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF July 29, 1950

NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery

LOCATION (City, town, or county) (State) Glen Burnie, Maryland

DATE REC'D BY LOCAL REG. July 28, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

RECEIVED
JUL 31 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06889

# CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Long Point a.a. Co. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Long Point a.a. co-md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 624 W. Redwood St

3. NAME OF DECEASED (Type or Print): (First) NELLIE (Middle) (Last) GRAY

4. DATE OF DEATH: (Month) 7 (Day) 8 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7/20/1894

9. AGE last birthday: 56 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Creed Randall

14. MOTHER'S MAIDEN NAME: Maggie D.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alberta Storrs 624 W. Redwood St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a) Acute congestive heart failure — Interval Between Onset and Death: 2 wks.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertension — unknown

(c) arteriosclerosis — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to July 8, 1950, that I last saw the deceased alive on July 7, 1950, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Randall M. McLaughlin, M.D. Pasadena. Md. July 8. 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: July 13-50

NAME OF CEMETERY OR CREMATORY: High Rock Church Cem

LOCATION (City, town, or county) (State): Prince Edward Co Va

DATE REC'D BY LOCAL REG. 7/13/50

REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: Rayner Sanders 1412 E Preston St

JT

VS-A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06890

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN: Annapolis (Rural)
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Rural
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Hester | Walker | Green | July | 10 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | colored | married | May 1896 | 54 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Annapolis | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William H. Johnson | Lucy Washington |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Maude Brashears, Annapolis, Md |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage | 1 day |
| 331X 83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | 2 yrs. |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 7/9/, 1950, to 7/10, 1950, that I last saw the deceased alive on 7/10, 1950, and that death occurred at 9:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Theodore L. Johnson M.D. — ADDRESS: 40 Northwest Street Annapolis, Md — DATE SIGNED: 7/11/50

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | July 14 1950 | Woodlawn Cem. | Edgemere, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| July 12, 1950 | [illegible] | J.B. Johnson | Annapolis, Md. |

VS. A15

RECEIVED
JUL 13 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06891

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven; LENGTH OF STAY (in this place) 7 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Catherine & 12th Sts.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven, Pasadena P.O.; STREET ADDRESS (If rural, give location) Catherine & 12th Sts. RFD 3 Box 83

3. NAME OF DECEASED (Type or Print): (First) Hattie (Middle) I. (Last) GREENE

4. DATE OF DEATH: (Month) July (Day) 25, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 1, 1879

9. AGE last birthday: 70 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife -

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Norfolk Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lemuel Ethridge

14. MOTHER'S MAIDEN NAME: (?) (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. (?)

17. INFORMANT: Mrs. Wilma F. GREENE

18. MEDICAL CERTIFICATION 631 Harvey St., Dale 39 Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) carcinomatosis | 1-2 months |
| 1717 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 48a | (b) carcinoma of cervix | 2 years. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 27, 1950, to July 25, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 10:35 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Randall M. McLaughlin M.D. Pasadena, Md. July 25. 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial - DATE THEREOF Fri. July 28 1950 NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery - LOCATION (City, town, or county) (State) Anne Arundel Co., Md

DATE REC'D BY LOCAL REG. 7/26/50 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR AND ADDRESS G. Howard Evans 1400 S. Charles St Balto 30 Md.

VS. A15

06892

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marley Neck Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Dorothy (Middle) Ann (Last) Hall

4. DATE OF DEATH (Month) July (Day) 16 (Year) 1950

5. SEX Female
6. COLOR OR RACE Colored.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) married
8. DATE OF BIRTH Aug 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dorchester County, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Oliver Nichols
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. None.
17. INFORMANT AND ADDRESS Wm. Hall - P.O. Glen Burnie, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Lobar Pneumonia | 8 days |
| 490x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Deformans Arthritis | 5 years |
| 108 | (c) Malnutrition | ? |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma — 2 years.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/14, 1950, to 7/15, 1950, that I last saw the deceased alive on 7/15/50, 19....., and that death occurred at 10.30 p.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauker MD. (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 7/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/19/50
NAME OF CEMETERY OR CREMATORY Mt Calvary
LOCATION (City, town, or county) (State) A.A. Co. Md

DATE REC'D BY LOCAL REG. 7/19/50
REGISTRAR'S SIGNATURE [signature] Dep
24. FUNERAL DIRECTOR James Castayes ADDRESS 6387 Pilmer St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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06893

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
STREET ADDRESS (If rural give location): 822 Chesapeake Avenue

3. NAME OF DECEASED (Type or Print): (First) Lewis (Middle) A. (Last) Hopkins

4. DATE OF DEATH: (Month) July (Day) 8 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: 11-4-1894

9. AGE last birthday: 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: House-builder

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William D. Hopkins

14. MOTHER'S MAIDEN NAME: Sarah Jane Revell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Josephine R. Hopkins - Wife

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Bronchial Pneumonia (Terminal) | 7 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma Stomach | Unknown |
| | (c) | |

151x
46b

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 3rd 1950

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Stomach

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1950, to July 8, 1950, that I last saw the deceased alive on July 8, 1950, and that death occurred at 4.30 P.M., from the causes and on the date stated above.

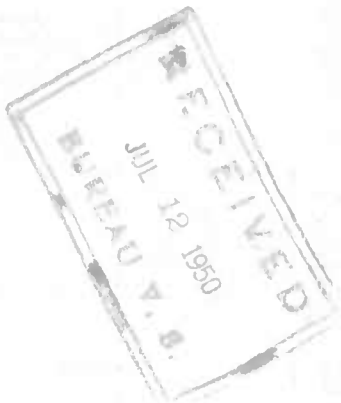
SIGNATURE: George E. Breil (Degree or title) M.D. ADDRESS: Annapolis Md. DATE SIGNED: 7-10-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF: 7-11-1950 | NAME OF CEMETERY OR CREMATORY: Cedar Bluff | LOCATION (City, town, or county): Annapolis (State): Md.

DATE REC'D BY LOCAL REG.: July 11, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: John B. Taylor & Son | ADDRESS: Annapolis, Md.

30509

VS. A15


RECEIVED
JUL 12 1950
BUREAU V. S.

Evidence on Film G127
accident, etc. 8-29-50

06894

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 1day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 204 Prince George St.

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) R. (Last) Howard

4. DATE OF DEATH (Month) July 18, (Day) 1950 (Year) 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 3-15-1875
9. AGE last birthday 75 yrs. If under 1 year Months 4 Days 3 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY own
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs Mary E. Smith Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 903.0 | Immediate cause | (a) Ac. Coronary Occlusion | Instantaneous |
| 186a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) shock of severe fall followed | 1 mo. |
| | | (c) by Senile psychosis | 1 mo. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Acc.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home*
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) July 4, 1950 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fall on floor 8/25/50 as

22. I hereby certify that I attended the deceased from June 12, 1950, to July 18, 1950, that I last saw the deceased alive on 7/17, 1950, and that death occurred at 6 A.m., from the causes and on the date stated above.

SIGNATURE Mannie Klawans, Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 7/19/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 20, 1950
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. July 20, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

* From Dr. Fisher's report.

RECEIVED
JUL 24 1950
BUREAU

Evidence foraddition in 9 shown on:
FILM No. G 1 28 SEP 15 1950

06895

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore.

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) 7½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Neta (Middle) (Last) Johnson
4. DATE OF DEATH (Month) 7 (Day) 27 (Year) 1950
5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH ?
9. AGE last birthday approx. 40 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Brand Raya
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General Paresis — Known to us since 1/10/50

025x

Antecedent cause(s)

30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10/, 1950, to 7/27, 1950 that I last saw the deceased alive on 7/27, 1950, and that death occurred at 7/27-5:00 a.m. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 7/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 8-2-50 NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. Cem. LOCATION (City, town, or county) Crownsville (State) Md.

DATE REC'D BY LOCAL REG. Aug. 1, 1950 REGISTRAR'S SIGNATURE M. E. [illegible]
24. FUNERAL DIRECTOR ADDRESS Crownsville State Hospital Md.

V3491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) E. (Middle) FLETCHER (Last) JOYCE

4. DATE OF DEATH (Month) July (Day) 18, (Year) 1950 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Sept 28, 1869

9. AGE last birthday 80 yrs. If under 1 year Months 9 Days 20 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Insurance

10b. KIND OF BUSINESS OR INDUSTRY Agent

11. BIRTHPLACE (State or foreign country) Odenton, Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William T. Joyce

14. MOTHER'S MAIDEN NAME Sarah M. Bargan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Mrs. Katherine Joyce Wife Millersville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Exhaustion from starvation

150x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Esophagus

46a

(c)

INTERVAL BETWEEN ONSET AND DEATH: 9 mos

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-10, 1949, to 7/18, 1950, that I last saw the deceased alive on 7/-17, 1950, and that death occurred at 12:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

O H Mac Nemar MD, Millersville Maryland

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF July 21, 1950

NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cemetery

LOCATION (City, town, or county) (State) Millersville, Maryland

DATE REC'D BY LOCAL REG. July 21, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

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JUL 24 1950
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06897

Evidence for addition of #18 shown on:

FILM No. G 1 28 SEP 25 1950

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Serverna Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Serverna Park
STREET ADDRESS (If rural, give location) Old Annapolis Blvd.

3. NAME OF DECEASED (Type or Print) (First) DONALD (Middle) RAY (Last) KNAPP

4. DATE OF DEATH (Month) July (Day) 17, (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH June 21, 1950

9. AGE last birthday yrs. If under 1 year Months Days 22 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Paul F. Knapp, Jr.

14. MOTHER'S MAIDEN NAME Violet Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT Paul F. Knapp, Sr.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Autopsy report: Acute interstitial pneumonitis. (9-25-50 - ams)

763.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

109 (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Stanley H. Durlacher per B. Fisher (Degree or title) M.D. ADDRESS 700 Fleet St., Baltimore 2, Md. DATE SIGNED July 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF July 18, 1950

NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.

LOCATION (City, town, or county) (State) Brooklyn R.F.D., Md.

DATE REC'D BY LOCAL REG. 7/12

REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR R. V. Singleton, Glen Burnie ADDRESS

2-0-6-21-0-21-3-38-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 19 1950
BUREAU V. S.

06898

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Severn
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Luedtke's Private Road H. New Cut Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. Anne Arundel COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) REGINA (Middle) M. (Last) LUEDTKE
4. DATE OF DEATH (Month) July (Day) 21 (Year) 1950
5. SEX F
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH March 23, 1924
9. AGE last birthday 26 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector
10b. KIND OF BUSINESS OR INDUSTRY Nat. Plastic Co.
11. BIRTHPLACE (State or foreign country) Johnstown Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME P Reffner
14. MOTHER'S MAIDEN NAME Alice Reffner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 188-20-7720
17. INFORMANT August Luedtke - husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Rheumatic Heart Disease years.

416X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

95b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4, 1950, to 7/21, 1950, that I last saw the deceased alive on 7/21, 1950, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE Bobby L. Jones (Degree or title) M.D. ADDRESS Glen Burnie Md DATE SIGNED 7/21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 24/50
NAME OF CEMETERY OR CREMATORY Luedtke Burial Grounds
LOCATION (City, town, or county) Glen Burnie (State) Md

DATE REC'D BY LOCAL REG. 7/24/50
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR Krause Funeral Home ADDRESS

JT 496431216 S. Charles St. Balto 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

06899

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Talbot |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 9 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Easton |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital | STREET ADDRESS (If rural, give location): |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) William | (Middle) Nathaniel | (Last) McGee | 4. DATE OF DEATH | (Month) 7 | (Day) 27 | (Year) 1950 |
| 5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 3/17/07 | 9. AGE last birthday: 43 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory | 11. BIRTHPLACE (State or foreign country): Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? U. S. | | | | |
| 13. FATHER'S NAME: Charles Brooks | 14. MOTHER'S MAIDEN NAME: Lavina McGee | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS: Hospital Records | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2

Immediate cause (a) Chronic Myocarditis — Known to us since 7/18/50

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 7/18, 1950, to 7/27, 1950, that I last saw the deceased alive on 7/27, 1950, and that death occurred at 5:55a.m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Jacob Marycrester M.D. | Crownsville, Maryland | 7/27/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ | DATE: Aug. 1, 1950 | NAME OF CEMETERY OR CREMATORY: Trappe | LOCATION (City, town, or county) (State): Trappe, Md |
| DATE REC'D BY LOCAL REG.: 7/29/50 | REGISTRAR'S SIGNATURE: N. H. Newnes, M. E. Joyce | 24. FUNERAL DIRECTOR: Leon W. Henry | ADDRESS: Easton 208 |

496 x 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S.

06900

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cypress Creek Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural give location) Cypress Creek Rd.

3. NAME OF DECEASED (Type or Print) (First) Folger (Middle) (none) (Last) McKinsey

4. DATE OF DEATH (Month) July (Day) 22 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH 8-29-1866
9. AGE last birthday 83 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Journalist
10b. KIND OF BUSINESS OR INDUSTRY Newspaper
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME James McKinsey
14. MOTHER'S MAIDEN NAME Catherine Nicol

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Lois McKinsey Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage | 3 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) General arterio-sclerosis | ? |
| | (c) Senility | ? |

331X
92b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mitral Insufficiency — 3 years

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June, 1948, to July 22, 1950, that I last saw the deceased alive on 7/22, 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE Gustave H. Fauber M.D. (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 7/23/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF July 26th 1950 NAME OF CEMETERY OR CREMATORY St Margarets LOCATION (City, town, or county) St Margarets (State) Md

DATE REC'D BY LOCAL REG. July 24, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

V 0414

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. S.

06901

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH — COUNTY: A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) FRANCIS (Last) NAYLOR
4. DATE OF DEATH: (Month) JULY (Day) 11, (Year) 1950
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1878
9. AGE last birthday: 71 yrs. — If under Months: — I year Days: — If under 24 hrs. Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT NAYLOR
14. MOTHER'S MAIDEN NAME: AURA PRATT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-16-2977
17. INFORMANT AND ADDRESS: MARGARET PRATT MAYO MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) acute coronary occlusion

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertension, arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-11, 1950, to 7-11-, 1950, that I last saw the deceased alive on 7-11-, 1950, and that death occurred at 11P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Emily H. Wilson, M.D. — ADDRESS: Lottician, Md. — DATE SIGNED: 7-13-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ — DATE: JULY 14, 1950 — NAME OF CEMETERY OR ~~CREMATORY~~: Hopes Chapel Gem Edgewater — LOCATION (City, town, or county) (State): Md

DATE REC'D BY LOCAL REG.: July 14, 1950 — REGISTRAR'S SIGNATURE: Edward Collinson — 24. FUNERAL DIRECTOR: A.A. Standerty + Son — ADDRESS: Gahsville Md.

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 17 1950
BUREAU V. S.

06902

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MHC Jessup, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1412 School Street

3. NAME OF DECEASED (Type or Print) (First) William (Middle) NMN (Last) Nelson
4. DATE OF DEATH (Month) July (Day) 31 (Year) 1950
5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~, (Specify)
8. DATE OF BIRTH Unknown
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Conjestive Heart Failure | 8 Days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Myocardial Degeneration | |
| | (c) Malnutrition | |

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24 1950, to July 31, 1950, that I last saw the deceased alive on July 31, 1950 and that death occurred at 1:55 P.m., from the causes and on the date stated above.

SIGNATURE John A. Clark (Degree or title) ADDRESS DATE SIGNED
JOHN A. CLARK, M. D., Physician in Charge, MHC Jessup, Md. 7/31/50

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF Aug 3, 1950 NAME OF CEMETERY OR CREMATORY Mt Auburn LOCATION (City, town, or county) Baltimore City (State)

DATE REC'D BY LOCAL REG. Aug 1-50 REGISTRAR'S SIGNATURE Clara Haslup
24. FUNERAL DIRECTOR Geo. T. Kelson ADDRESS 303 Pressman St.

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 8 1950
BUREAU F. S

MARYLAND STATE DEPARTMENT OF HEALTH

06903

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach; LENGTH OF STAY (In this place): 1½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Patapsco River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1502 Linwood Ave

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JAMES | | PATTERSON | July | 16 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | June 27, 1938 | 12 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | School | Georgia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Allen Patterson | Mildred Anna Pittard |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | — | Leo E. Norak |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 929.8 Immediate cause | (a) Drowning | |
| 183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Accidental | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | CITY OR TOWN | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Patapsco River | Riviera Beach | A.A. | Md |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at work ☐ | Not while at work ☑ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|---|
| July | 16 | 1950 | 3:45 p.m. | | | Inner tube blew out while swimming in River |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from, natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wm. M. Lefty M.D. | Deputy Medical Examiner | Annapolis, Md | 7/16/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | July 20-50 | St. Stanislaus | Balto. City | |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 7/19/50 | [signature] | Wm. S. Fiolkowski | 2007 Eastern Ave |

MARYLAND STATE DEPARTMENT OF HEALTH

06904

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 115

**1. PLACE OF DEATH**
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum
LENGTH OF STAY (in this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum
STREET ADDRESS (If rural, give location): 311 Hammonds Fairy Road

**3. NAME OF DECEASED (Type or Print)**: (First) Walter (Middle) (Last) Petry

**4. DATE OF DEATH**: (Month) July (Day) 15, (Year) 1950

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)**: Married

**8. DATE OF BIRTH**: Nov. 5, 1899

**9. AGE last birthday**: 50 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**: Labor organizer

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE (State or foreign country)**: Ontario, Canada

**12. CITIZEN OF WHAT COUNTRY?**: Yes

**13. FATHER'S NAME**: Atim Petry

**14. MOTHER'S MAIDEN NAME**: ?

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: No — (If year, give war or dates of service)

**16. SOCIAL SECURITY No.**: 029-01-1544

**17. INFORMANT AND ADDRESS**: Dorothea Petry

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Lung with metastasis to liver — 10 mos.

162x

Antecedent cause(s)

47d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**: Jan 1950

**19b. MAJOR FINDINGS OF OPERATION**: Tumor of Lung

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**:

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from Nov., 1949, to July 15, 1950, that I last saw the deceased alive on July 14, 1950, and that death occurred at 12.45 P m., from the causes and on the date stated above.

SIGNATURE: J. M. Applebaum — (Degree or title): MD — ADDRESS: 803 Cathedral St — DATE SIGNED: 7-17-50

**23. BURIAL, CREMATION, REMOVAL (Specify)**: Burial — DATE: July 20-1950 — NAME OF CEMETERY OR CREMATORY: Stanstead — LOCATION (City, town, or county): Quebec — (State): Canada

DATE REC'D BY LOCAL REGISTRAR: 7/17/50 — REGISTRAR'S SIGNATURE: H. W. Hedrick

**24. FUNERAL DIRECTOR** — ADDRESS: Joseph Kasinskas, Inc. 602 Wash. Blvd

496 83

06905

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 12 German Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
STREET ADDRESS (If rural, give location): 12 German Street

3. NAME OF DECEASED (Type or Print): (First) LEONARD (Middle) C. (Last) PHIPPS

4. DATE OF DEATH: (Month) July (Day) 8, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-5-1891

9. AGE last birthday: 59 yrs. If under 1 year: Months 6, Days 3. If under 24 hrs.: Hours -, Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: CARPENTER SELF EMPLOYED

11. BIRTHPLACE (State or foreign country): Deale, A.A. Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Julius Phipps

14. MOTHER'S MAIDEN NAME: Rachel Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 214-05-0434

17. INFORMANT AND ADDRESS: Pauline C. Phipps 12 German St. Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Carcinoma of Pancreas | unknown |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Metastasis to Stomach & liver | unknown |
| | (c) Diabetes Mellitus | several years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1949, to July 4, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 3:15 p m., from the causes and on the date stated above.

SIGNATURE: John M. Caffy (Degree or title) M.D. ADDRESS: Annapolis Maryland DATE SIGNED: 7-9-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: July 10, 1950
NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
LOCATION (City, town, or county) (State): Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.: July 10, 1950
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: B.L. Hopping and Son ADDRESS: Annapolis, Md.

30849

RECEIVED
JUL 11 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

06906

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Allie (Middle) (Last) Pratt

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar 17 1891

9. AGE last birthday: 59 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm tenant

10b. KIND OF BUSINESS OR INDUSTRY: Retired FARMER

11. BIRTHPLACE (State or foreign country): Tracey Ind

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT AND ADDRESS: David Pratt Bristol Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

446 x Immediate cause (a) Cerebral Embolism — Interval Between Onset and Death: 10 days

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — 10 yrs

(c) Nephritis — 8 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — 15 yrs

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 1950, to July 18, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James E. Sasscer M.D. — Upper Marlboro - Md

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE: 7-21-50 | NAME OF CEMETERY OR CREMATORY: Groundbirth | LOCATION (City, town, or county): Groundbirth (State): Md

DATE REC'D BY LOCAL REG. 7/21/50 | REGISTRAR'S SIGNATURE: H.M. Clayton

24. FUNERAL DIRECTOR: T.C. Hardesty & Son ADDRESS: Hyattsville Md

8000

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JUL 24 1990

06907

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis
LENGTH OF STAY (in this place): 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 25 Annapolis Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis,
STREET ADDRESS (If rural, give location): 25 Annapolis Street

3. NAME OF DECEASED (Type or Print): (First) LOIS (Middle) L (Last) PRUETT

4. DATE OF DEATH: (Month) July (Day) 18, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widwoed

8. DATE OF BIRTH: Sept. 4, 1886

9. AGE last birthday: 63 yrs. If under 1 year: Months 10, Days 12. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Chicago, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 335-03-6656

17. INFORMANT AND ADDRESS: Mr Raymond J. Swallow West Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis — Interval Between Onset and Death: Several yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — Interval Between Onset and Death: Several yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1948, to July 18, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 7 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C Basil M. D. Annapolis Md 7-18-50

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: July 19, 1950 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Chicago, Ill

DATE REC'D BY LOCAL REG.: July 19, 1950 — REGISTRAR'S SIGNATURE: W. J. Smith

24. FUNERAL DIRECTOR ADDRESS: B. L. Hopping and Son Annapolis, Md

52087

RECEIVED
JUL 20 1950
BUREAU V. S.

06908

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

M

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
LENGTH OF STAY (in this place) 2 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1237 GUILFORD ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
STREET ADDRESS (If rural, give location) 1237 GUILFORD ROAD

3. NAME OF DECEASED (Type or Print) (First) DELLA (Middle) E (Last) RETZLER

4. DATE OF DEATH (Month) JULY (Day) 7 (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH AUG. 6, 1885
9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK RETIRED
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME.
11. BIRTHPLACE (State or foreign country) PITTSBURG P.A.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME JOHN DRUDY
14. MOTHER'S MAIDEN NAME UNKNOWN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ~~NONE~~ UNKNOWN.
17. INFORMANT AND ADDRESS JOSEPH J. RETZLR GLEN BURNIE MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 145x | Immediate cause | (a) Generalized Carcinomatosis | 4 mos |
| 45f | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Symptom of Pathology at Tonsil | 4 mos |
| | | (c) Hypostatic pneumonia | 4 days |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1950 to 7/7, 1950, that I last saw the deceased alive on 7/7, 1950, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

SIGNATURE R.W. Pickard (Degree or title) ADDRESS Gl. Burnie, Md DATE SIGNED 7/8/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF JULY 11, 1950
NAME OF CEMETERY OR CREMATORY CALVERY
LOCATION (City, town, or county) PITTSBURGH (State) PA.

DATE REC'D BY LOCAL REG. 7/8/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
JUL 11 1950
BUREAU V. S.

06909

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundle MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundle |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 2 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital | STREET ADDRESS (If rural give location) 821 Bay Ridge Avenue |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Dale | (Middle) Howard | (Last) ROHN | 4. DATE OF DEATH | (Month) July | (Day) 24 | (Year) 1950 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH July 22, 1950 | 9. AGE last birthday yrs. | If under 1 year Months 0 | Days 2 | If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — — — — — | 10b. KIND OF BUSINESS OR INDUSTRY — — — | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Rhea William ROHN | | 14. MOTHER'S MAIDEN NAME Mildred Ethel Jacobs | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — — (If yes, give war or dates of service) — — | 16. SOCIAL SECURITY NO. — — | 17. INFORMANT U.S. Naval Hospital Records | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Encephalopathy | 1 day |
| 773.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cause Unknown | |
| 87e | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from July 22, 1950, to July 24, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 7:32 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| K.M. Coverdale | K.M. Coverdale, LTJG, MC USN | U.S. Naval Hospital, Annapolis, Md. | July 25, 1950 |

| | | | | |
|---|---|---|---|---|
| 23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF July 25th 50 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis | (State) Md |
| DATE REC'D BY LOCAL REG. July 25, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR John M. Taylor Son | ADDRESS Annapolis Md. | |

2-0-7-22-0-32-5-40-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 26 1960
BUREAU T. S.

Not B.C.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

06910

**1. PLACE OF DEATH**

County Anne Arundel Registration Dist. No. 27

Village or City Riviera Beach No. Carroll Rd. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** George S. Rossiter

(a) Residence: No. 1001 S. Hanover St. St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Rossiter

6. DATE OF BIRTH (month, day, and year): Sept. 18, 1884

7. AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Restaurant

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Owner

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation: 35yrs.

12. BIRTHPLACE (city or town) (State or country): Balto. Md.

FATHER

13. NAME: John Rossiter

14. BIRTHPLACE (city or town) (State or country): ~~IRELAND~~ Ireland

MOTHER

15. MAIDEN NAME: Margaret Murphy

16. BIRTHPLACE (city or town) (State or country): Ireland

17. INFORMANT (Address): Anna Rossiter wife 1001 S. Hanover St.

18. BURIAL, CREMATION, OR REMOVAL — Place: New Cathedral Cem. Date: July 4, 1950

19. UNDERTAKER (Address): KRAUSE FUNERAL HOME 1216 S. Charles St.

20. FILED 7-5, 1950 L Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** July 1, 1950. (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 6/8, 1949, to 7/1, 1950.

I last saw him alive on 6/30/50, 19; death is said to have occurred on the date stated above, at 10 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Carcinoma of bowel with general metastases, — Date of onset 6/49

Other Contributory Causes of Importance: Diabetes Mellitus — 3

153x

46e

Name of operation: Resection of bowel Date of July 1949

Whet test confirmed diagnosis? Operation Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no.

If so, specify

(Signed) Harry Deilee M.D.

(Address) 1226 Hanover Street,

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

15671

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

M

I

T

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I | | Example II | |
|---|---|---|---|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| *Arteriosclerosis* | *1915* | *Attack of epilepsy* | *1 week ago* |
| *Chronic interstitial nephritis* | *1921* | *Run over by street car* | *1 week ago* |
| *Cerebral hemorrhage* | *July 5, 1927* | *Peritonitis* | *3 days ago* |
| | | | |
| | | | |
| Other contributory causes of importance: | | Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* | *Gastroenteritis* | *1 year* |
| | | | |
| | | | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

06911

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 28 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Round Bay at Herald Harbor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe
STREET ADDRESS (If rural give location) 27 Elm Road.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JANET | LORINE | SACHSE | July | 25 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | | 7-18-1937 | 13 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | School | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HENRY SACHSE | LORINE LOVELL |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | | E. Charles Jackson |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| 9298 Immediate cause (a) Drowning | |
| 183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental | |
| (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Round Bay | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | near Crownsville | A.A. | Md |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| July 25 1950 3:40 p.m. | | Was in water supported by swim tube - |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| John M. Klaffy, M.D. Deputy Medical Examiner | Annapolis Md | 7-25-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 7-29-50 | London Park | Baltimore | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| July 26, 1950 | [signature] | Wm J. Jackson & Son Co. Inc. | Balto. Md. |

VS. A15A

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JUL 31 1950
BUREAU V. S.

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06912

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print) (First) BROWNIE (Middle) SASADA (Last)

4. DATE OF DEATH (Month) July (Day) 20, (Year) 1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 28, 1891
9. AGE last birthday 58 yrs. If under 1 year Months 9 Days 22 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Boat Construction
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Sasada
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Miss Dorothy Sasada Arnold, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 420.1 Immediate cause | (a) Coronary Thrombosis with | 3 days |
| 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Posterior Infarction and | |
| | (c) Complete Heart Block | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 17, 1950, to July 20, 1950, that I last saw the deceased alive on July 20, 1950, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE George C. Boid (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 7.22.50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 24, 1950
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. July 21, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

308 49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JUL 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

66913

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis; MARYLAND; LENGTH OF STAY (In this place): 10 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dreems Landing Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,; STREET ADDRESS (If rural, give location): Dreems Landing Rd.

3. NAME OF DECEASED (Type or Print): (First) BERTHA (Middle) (Last) SLOVENSKI

4. DATE OF DEATH: (Month) July (Day) 16, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 10, 1865

9. AGE last birthday: 85 yrs. If under 1 year: Months 4, Days 6; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Emma Platt Dreems Landing Rd Annapolis, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Dilatation of Heart — Interval Between Onset and Death: sudden

443x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-vascular - hypertensive disease — Interval Between Onset and Death: unknown

932

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Gatty M.D., Deputy Medical Examiner, Annapolis, Md. July 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Removal — DATE THEREOF: July 17, 1950 — NAME OF CEMETERY OR CREMATORY: to — LOCATION (City, town, or county) (State): Philadelphia, Pa

DATE REC'D BY LOCAL REG.: July 17, 1950 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: B.L. Hopping and Son Annapolis, Md

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JUL 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

06914

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: A. A. | MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn | LENGTH OF STAY (in this place) | HOSPITAL OR INSTITUTION OR STREET ADDRESS: 151 Meadow Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md | COUNTY: A. A. Co. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn | STREET ADDRESS (If rural give location): 151 Meadow Rd

3. NAME OF DECEASED (Type or Print): (First) George (Middle) E (Last) Smith

4. DATE OF DEATH: (Month) July (Day) 11 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widower

8. DATE OF BIRTH: Nov. 27, 1878

9. AGE last birthday: 71 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R

11. BIRTHPLACE (State or foreign country): Sandy Hook Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Smith

14. MOTHER'S MAIDEN NAME: Sarah Ada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705 09 9279

17. INFORMANT: Mrs Thelma Nagle (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Heart failure

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio vascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 8, 1950, to July 11, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 5:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Samuel Rubin M.D. 203 Patapsco Ave Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: July 14 1950 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county) (State): A.A. Co

DATE REC'D BY LOCAL REG. 7/11/50 | REGISTRAR'S SIGNATURE: A W Adams

24. FUNERAL DIRECTOR: C. Howard Evans | ADDRESS: 1400 Charles St

41247

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

66915

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 900 Creek Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New Jersey; COUNTY Monmouth; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asbury Park; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Jane (Last) Smith

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 1950

5. SEX: female

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 3-19-1858

9. AGE last birthday: 92 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Arvin Pease

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: W. Harold Smith 3709 Brandywine St. Washington 16, DC.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis

422.1 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

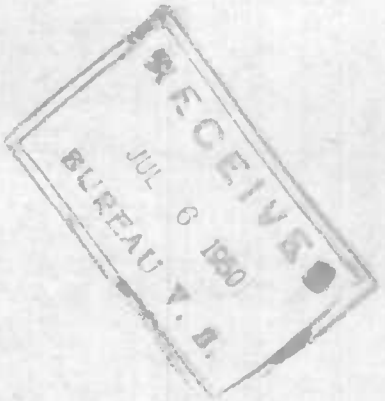
22. I hereby certify that I attended the deceased from 6-27, 1950, to 7-2, 1950, that I last saw the deceased alive on 7-1, 1950, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE: C M Lowe (Degree or title) M.D. ADDRESS: 90 Cathedral St Annapolis Md. DATE SIGNED: 7/3/50

23. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~ | DATE: 7/5/50 | NAME OF CEMETERY OR CREMATORY: Monmouth Mem. Park | LOCATION (City, town, or county) (State): Asbury Pk. N.J.

DATE REC'D BY LOCAL REG.: July 3, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR ADDRESS: John M. Taylor Son Annapolis M.D.

VS. A15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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06916

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL, ANNAPOLIS, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 47½ South Gate Ave.,

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Robinson (Last) SMITH Jr.
4. DATE OF DEATH (Month) 7 (Day) 31 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 10-6-1887
9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy Retired
10b. KIND OF BUSINESS OR INDUSTRY CDR., USN
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Deceased
14. MOTHER'S MAIDEN NAME Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. - - - - - -
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 540.1 Immediate cause | (a) PERITONITIS ACUTE DIFFUSE | Several days |
| 117a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) PERFORATION STOMACH DUE TO PREPYLORIC ULCER | Several days |
| | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CIRRHOSIS LAENNEC'S

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 July, 1950, to 31 July, 1950, that I last saw the deceased alive on 31 July, 1950, and that death occurred at 1240 P. m., from the causes and on the date stated above.

SIGNATURE G. M. Davis (Degree or title) ADDRESS DATE SIGNED
G.M. DAVIS, CDR., MC, USN 7-31-50

23. ~~BURIAL~~, CREMATION ~~REMOVAL (Specify)~~ DATE THEREOF 8/3/1950 NAME OF CEMETERY OR CREMATORY LOUDON PARK LOCATION (City, town, or county) BALTIMORE (State) Md.

DATE REC'D BY LOCAL REG. Aug. 2, 1950 REGISTRAR'S SIGNATURE [signature] 11296
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

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AUG 13 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06917

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY AA Annapolis (Rural) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena | LENGTH OF STAY (in this place) 70 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Dorsey Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md. (Rur)
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Smothers

4. DATE OF DEATH: (Month) 7 (Day) 14 (Year) 1950

5. SEX: M

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 4-18-1880

9. AGE last birthday: 70 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming tenant

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Lothian AA. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Smothers

14. MOTHER'S MAIDEN NAME: Lucy Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mary Hawkins

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of liver

156.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46f (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) Annapolis | (COUNTY) AA | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-30-50, 19..., to 7-14, 1950, that I last saw the deceased alive on 7-10, 1950, and that death occurred at 7:05 A. m., from the causes and on the date stated above.

SIGNATURE G. I. Allen (Degree or title) ADDRESS 10 Carroll DATE SIGNED 7-14-50

23. BURIAL, CREMATION, REMOVAL (Specify) B | DATE THEREOF 7-18-50 | NAME OF CEMETERY OR CREMATORY Chaves Chapel Cemetery | LOCATION (City, town, or county) West River AA | (State) Md.

DATE REC'D BY LOCAL REG. July 15, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR William Reese | ADDRESS 108 Wash. St. Annapolis, Maryland.

RECEIVED
JUL 19 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

06918

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Crownsville, A. A. Co. STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
LENGTH OF STAY (in this place): 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): 217 N. Vincent Street

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) W. (Last) THOMPSON

4. DATE OF DEATH: (Month) July (Day) 15, (Year) 1950

5. SEX: male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1877 (?)

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Thompson

14. MOTHER'S MAIDEN NAME: Susan Clinton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Crownsville State Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) GENERAL PARESIS — Interval between onset and death: 7/20/35

025 X

Antecedent cause(s)

30 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — to

(c) — 7/15/50

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/20/35, 19....., to 7/15/50, 19....., that I last saw the deceased alive on July 15, 19 50, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

SIGNATURE: Jacob Thompson M. D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: 7/18/50 — NAME OF CEMETERY OR CREMATORY: Maryland Med & Chirurg — LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG. 7/18/50 — REGISTRAR'S SIGNATURE: L. E. Beall

24. FUNERAL DIRECTOR: Frances A Hemsley — ADDRESS: 578 W Biddle St

98647

RECEIVED
JUL 19 1950
BUREAU V. S.

06919

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft. George Meade — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Found dead in field at Ft. George Meade

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland Anne Arundel Prince George's D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel Washington
STREET ADDRESS (If rural, give location) District Training School

3. NAME OF DECEASED (Type or Print): (First) RAYMOND (Middle) (Last) THORN
4. DATE OF DEATH: (Month) July (Day) 16 (found) (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 7-25-33
9. AGE last birthday: 16 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inmate
10b. KIND OF BUSINESS OR INDUSTRY: Student
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clayton Thorne
14. MOTHER'S MAIDEN NAME: Alice Gillotte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Records of D.T.S., Laurel, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

981 X Immediate cause (a) Multiple bullet wounds of trunk

166 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Field
(CITY OR TOWN) (COUNTY) (STATE) Ft. George Meade, A. A. Co.
TIME OF INJURY (Month) (Day) (Year) (Hour) ? ? m.
INJURY OCCURRED While at work [ ] Not while at work [X]
HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ] therean and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

SIGNATURE (Degree or title) Stanley H. Dunbaugh, M.D. ADDRESS 700 Fleet St., Balto.2, Md. DATE SIGNED July 21, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/22/50
NAME OF CEMETERY OR CREMATORY Congressional, Wash. D.C.
LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REG. July 21, 50
REGISTRAR'S SIGNATURE Clara Kaslup
24. FUNERAL DIRECTOR SIMMONS - 2007 Nichols Ave. ADDRESS Washington D.C.

RECEIVED
AUG 8 1980
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

06920

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Grundel Gen Hospital Annapolis Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) - (Last) Turner

4. DATE OF DEATH: (Month) July (Day) 14 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan 8, 1886

9. AGE last birthday: 64 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: House work

11. BIRTHPLACE (State or foreign country): Churchton Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Turner

14. MOTHER'S MAIDEN NAME: Ellen Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Gertrude Turner Shady Side Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Hypostatic Pneumonia | 24 hrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Glomerular Nephritis | ? |
| 023X 30d | (c) Syphilitic Aortitis | ? |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Fibroma of Uterus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10/, 1950, to 7/14/, 1950, that I last saw the deceased alive on 7/14/, 1950, and that death occurred at 2 45 p m., from the causes and on the date stated above.

SIGNATURE: Frank W Shipley (Degree or title) M.D. ADDRESS 63 College Ave. Annapolis DATE SIGNED 7/14/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF July 17, 1950 NAME OF CEMETERY OR CREMATORY St Matthews LOCATION (City, town, or county) Shady Side (State) Md

DATE REC'D BY LOCAL REG. July 17, 1950 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR W. A. Hardesty & Son ADDRESS Galesville Md.

5208

RECEIVED
JUL 18 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

06921

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Calvert Court

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 2 Calvert Court

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Elizabeth (Last) Turner

4. DATE OF DEATH: (Month) July (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Oct. 11, 1888

9. AGE last birthday: 61 yrs. If under 1 year: Months 8, Days 27; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): D. C. Co. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Owens

14. MOTHER'S MAIDEN NAME: Jennie Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Margie Brown, Calvert Court Ann. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cardiac Failure | 1 day |
| 449X 932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio Vascular Disease | 6 wks |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/7/50, 19..., to 7/7/50, 19..., that I last saw the deceased alive on 7/7/50, 19..., and that death occurred at 9:30 P. M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Theodore R. Johnson M. D.

ADDRESS: 40 Northwest Street

DATE SIGNED: 7/11/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE THEREOF: July 12, 1950; NAME OF CEMETERY OR CREMATORY: Moses Cemetery; LOCATION (City, town, or county) (State): Drury, A. Co. Md

DATE REC'D BY LOCAL REG.: July 12, 1950

REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: J. B. Johnson, Annapolis, Md.

ADDRESS

RECEIVED
JUL 13 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06922

# CERTIFICATE OF DEATH

Reg. Dist. No. 2/

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Arnold; LENGTH OF STAY (in this place) 7 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Mago Vista

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold — Rural; STREET ADDRESS (If rural give location) Mago Vista

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) (Last) Wagner

4. DATE OF DEATH: (Month) 7 (Day) 22 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 5-22-1866

9. AGE last birthday: 84 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Mayer

14. MOTHER'S MAIDEN NAME: Marie Muhlhauser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Rose Wagner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of bladder — Interval Between Onset and Death: 5 mos

191.X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

52b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-1, 1950, to 7-22, 1950, that I last saw the deceased alive on 7-21, 1950, and that death occurred at 2:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Charles R. MacDonald M.D. Odenton, Md. 7-22-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 7/24/50 — NAME OF CEMETERY OR CREMATORY: Balto. — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 7/24/50 — REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR: Wm. J. Tschner & Sons — ADDRESS: Balto Md.

JT

VS. A15

06923

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 2 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Generals Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
STREET ADDRESS R.F.D. (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) HARRISON (Last) WILLIAMS
4. DATE OF DEATH (Month) July (Day) 22 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH DEC. 29. 1889
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY BUILDING
11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES WILLIAMS
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. 224-18-4242
17. INFORMANT MACIE May Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Dilatation of Heart | Sudden |
| 443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Cardio-Vascular-Hypertensive Disease | 2 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 7-22-50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF July 23, 1950
NAME OF CEMETERY OR CREMATORY TO
LOCATION (City, town, or county) (State) Bristol, Virginia
DATE REC'D BY LOCAL REG. July 23, 1950
REGISTRAR'S SIGNATURE [signature] E. Fletcher Joyce
24. FUNERAL DIRECTOR B.L. Hopping & Son, ADDRESS Annapolis Md.

308V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 25 1950
BUREAU P. R.

06924

Evidence for change of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

FILM No. G 126 JUL 11 1950

1. PLACE OF DEATH — COUNTY: Anna Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 24 Gotts Court

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 24 Gotts Court

3. NAME OF DECEASED (Type or Print) (First): Maude (Middle): Jones (Last): Woods
4. DATE OF DEATH (Month) (Day) (Year): 7 / 1 / 50

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 5/ 11 / 1909
9. AGE last birthday: ~~42~~ 41 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid (Domestic)
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Mt. Tabor A.A.Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Jones
14. MOTHER'S MAIDEN NAME: Liddie Bradford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ------ (If yes, give war or dates of service) ------
16. SOCIAL SECURITY No.: ----------
17. INFORMANT: Robert Woods

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Apoplexy | 1 day |
| 443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Hypertensive Cardio Vascular Disease | 6 wks |
| | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. No

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/2/50, 19....., to 7/1/50, 19....., that I last saw the deceased alive on 7/1/50, 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: Theodore L. Johnson M.D. (Degree or title) — ADDRESS: 40 Northwest Street — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 7/5/1950 — NAME OF CEMETERY OR CREMATORY: Asbury Cemetery — LOCATION (City, town, or county) (State): Annapolis Md.

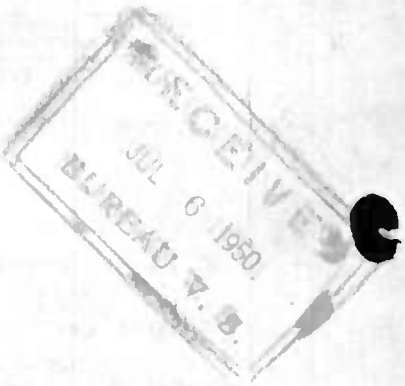
DATE REC'D BY LOCAL REG.: July 5, 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks & Son — ADDRESS: 45 Northwest st.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15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JUL 6 1950
BUREAU U. S.